



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
Effective July 1, 2014



**Provider Synergies, an affiliate of Magellan Medicaid Administration,
Virginia Medicaid's Pharmacy Service Administrator
Phone: 1-800-932-6648 Fax: 1-800-932-6651**

General Information:

- The PDL is a list of preferred drugs, by select therapeutic class, for which the Medicaid Fee-for-service program allows payment without requiring service authorization (SA).
- *Please note that not all drug classes are subject to the Virginia Medicaid PDL.* In the designated classes, drug products classified as non-preferred will be subject to SA. In some instances, other additional clinical criteria may apply to a respective drug class which could result in the need for a SA.
- This list is not all inclusive for non-preferred drugs.
- Fax requests receive a response within 24 hours.
- For urgent requests, please call **1-800-932-6648**.
- Not all medications listed are covered by all DMAS programs. Check individual program coverage.
- All new products included in a PDL class are non-preferred until reviewed by the P&T Committee.

For PDL drug coverage information, visit the following: <http://www.VirginiaMedicaidPharmacyServices.com>. The following “routine” PDL criteria guidelines will be applied to non-preferred drugs requiring a Service Authorization. Some drug classes will have additional criteria that will be listed alongside the drug class.

1. Is there any reason the patient cannot be changed to a medication not requiring service authorization within the same class?
Acceptable reasons include:
 - Allergy to medications not requiring service authorization
 - Contraindication to or drug-to-drug interaction with medications not requiring service authorization
 - History of unacceptable/toxic side effects to medications not requiring service authorization
 - Patient's condition is clinically stable; changing to a medication not requiring service authorization might cause deterioration of the patient's condition.
2. The requested medication may be approved if both of the following are true:
 - If there has been a therapeutic failure of no less than a **one-month trial** of at least **one** medication **within the same class** not requiring service authorization
 - The requested medications corresponding generic (if a generic is available and covered by the State) has been attempted and failed or is contraindicated.

All changes from last posting will be highlighted in yellow.

Teal highlights indicate where a Brand is preferred over a generic

Drugs no longer available have been removed from this list.



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Preferred Agents	Non-Preferred Agents	SA Criteria
Analgesics		
Narcotics – Long Acting (LAN)		
fentanyl patch Kadian® ER *methadone 10 mg/5mL & 5mg/5mL oral soln *methadone 5mg & 10mg tab morphine sulfate tab SA	<i>Avinza®</i> <i>Butrans®</i> <i>Conzip® ER</i> <i>*Dolophine®</i> <i>Duragesic®</i> <i>Embeda®</i> <i>Exalgo®</i> <i>*Methadose®</i> <i>morphine ER (Avinza®)</i> <i>morphine ER (Kadian® ER)</i> <i>MS Contin®</i> <i>Nucynta® ER</i> <i>Opana® ER</i> <i>Oramorph® SR</i> <i>oxycodone-long acting</i> <i>OxyContin®</i> <i>oxymorphone ER</i> <i>Ryzolt™</i> <i>tramadol ER</i> <i>Ultram ER®</i> <i>Xartemis™ XR</i> <i>Zohydro ER™</i>	LENGTH OF AUTHORIZATIONS: - Up to 6 months after trial and failure of 2 different short acting narcotics OR - Up to one year for cancer and sickle cell OR - One to three months for chronic non-malignant pain Clinical Criteria for LAN - If diagnosis is chronic non-malignant pain they must have : - A treatment plan that includes a diagnosis & goals of therapy. - Documentation of provision of an assessment of addiction risk with the therapy. - Attestation from prescriber that the Virginia Board of Pharmacy Prescription Drug Monitoring Program database has been recently reviewed - Be aware of the request for possible random urine drug testing - A pain management contract that addresses the following: - The consequences of unexplained loss or shortage of medications - The consequences of obtaining similar prescription medications from other prescribers; - An agreement with the patient to only use one pharmacy. Additional PDL edit - Approval of non-preferred agents in this class requires: - Contraindication to all PDL preferred agents, or - drug to drug interaction to all PDL preferred agents, or history of toxic side effects from all PDL preferred agents that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents *Clinical Criteria for Methadone All methadone agents receive a clinical edit to determine reason for use. Low dose strengths are generally used for pain. Please see criteria for clinical edit for methadone 40mg dispersible tablets and 10mg/mL oral concentrated solution for detoxification and maintenance treatment of narcotic addiction.



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Narcotics – Short Acting		
Barbiturate & Non-Salicylates Analgesic Combinations		LENGTH OF AUTHORIZATIONS: 3 months
acetaminophen-butalbital	Orbivan CF [®] Phrenilin Forte [®] Sedapap	Routine PDL edit plus Clinical Criteria for narcotic lozenges
Lozenges - Narcotic		• Diagnosis of breakthrough cancer pain • Patient is receiving around-the-clock scheduled long-acting narcotics; AND • Patient is receiving and tolerant to other opioids as indicated by one of the following: ○ At least 60 mg of morphine per day for at least one week without adequate pain relief; OR ○ At least 25 mcg/hr of transdermal fentanyl for at least one week without adequate pain relief; OR ○ At least 30 mg oxycodone per day for at least one week without adequate pain relief; OR ○ At least 8 mg hydromorphone per day for at least one week without adequate pain relief; OR ○ An equianalgesic dose of another opioid for at least one week without adequate pain relief; AND • Patient has tried and failed at least two immediate release opioid products (e.g., oxycodone, immediate-release morphine, hydromorphone) for breakthrough pain OR has a contraindication, intolerance, or drug-to-drug interaction with at least two immediate release opioid products
	Actiq [®] Fentora [®] fentanyl citrate Onsolis [®]	
Opioid Dependency - Methadone products		*Clinical Criteria for methadone 40mg dispersible tablets & 10mg/mL oral concentrated solution
* Diskets [®] 40mg * methadone 10mg/mL Intensol oral concentrated soln *methadone 10mg/mL oral concentrated soln *methadone 40 mg *Methadose [®] 10mg/mL oral concentrated soln *Methadose [®] 40 mg		• FDA approved ONLY for detoxification and maintenance treatment of narcotic addiction • Patient must be enrolled in a methadone treatment program (opioid treatment program, OTP) • Dispensed only by opioid treatment programs (and agencies, practitioners, or institutions by formal agreement with the program sponsor) certified by the Federal Substance Abuse and Mental Health Services Administration and registered by the Drug Enforcement Administration (DEA).



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Opioid Dependency - Buprenorphine products		**Clinical Criteria for buprenorphine SL, buprenorphine/naloxone tablets, Suboxone[®] SL/Film, & Zubsolv[™]
buprenorphine SL **Suboxone[®] film * naltrexone tablet	**buprenorphine/naloxone tab **Zubsolv[™]	• Diagnosis of opiate abuse/dependence. • Prescribed by a qualified prescriber who has ○ A Substance Abuse and Mental Health Services Administration Waiver and has ○ An active “X” DEA number AND ○ The prescription is written under the “X” DEA number such that this patient counts toward the patient limits established for individual prescribers by the DATA 2000 waiver. • The prescriber has reviewed the Virginia Controlled Substance Database. • Patient is receiving addiction counseling. • A chemical dependency assessment has been performed AND • Criteria for chemical dependency are met. • Patient is 16 years of age or older (no exceptions allowed); AND • Patient is not pregnant (Suboxone[®] SL/Film, buprenorphine/ naloxone, and Zubsolv). • Max duration is 24 months • Max dose is 16mg/day Suboxone[®]. Zubsolv[™] Quantity Limit = 68 tablets / 34 days
		***Clinical Criteria for naltrexone oral • Must have a diagnosis of ○ Alcohol dependence OR ○ Opioid dependence ▪ Do not attempt treatment with naltrexone unless, in the medical judgment of the prescriber, there is no reasonable possibility of opioid use within the past 7 to 10 days. If there is any question of occult opioid dependence, perform a naloxone challenge test.
Short-Acting Narcotics		Revised from routine PDL edit short acting narcotics
codeine/APAP codeine/APAP/caff/butal codeine/ASA	<i>All Brands require a SA</i> <i>Abstral[®]</i> <i>codeine tab/soln</i>	• Approval of non-preferred agents in this class requires: ○ Contraindication to all PDL preferred agents, or ○ Drug to drug interaction to all PDL preferred agents, or



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	hydrocodone/APAP hydrocodone/ASA hydrocodone/ibuprofen hydrocodone bitartrate/APAP hydromorphone morphine IR nalbuphine oxycodone IR oxycodone/APAP tramadol HCL	butalbital comp with codeine butorphanol tartrate nasal dihydrocodeine/APAP/cafeine dihydrocodeine/ASA/cafeine hydromorphone liq/supp meperidine tab Nucynta [®] Oxecta [®] oxycodone/ASA oxycodone/ibuprofen oxymorphone HCl pentazocine/naloxone PrimLev TM tramadol HCL / APAP Ultracet [®] Ultram [®] Zydone [®] Zolvit [®]	History of toxic side effects from all PDL preferred agents that cause immediate or long-term damage (NOTE: this does not include GI intolerance) with ALL preferred agents
Non-Steroidal Anti-Inflammatory Drugs			
	Children's ibuprofen susp (OTC) ibuprofen (OTC & RX) Infant's ibuprofen drops susp OTC meloxicam tab nabumetone naproxen naproxen sodium piroxicam sulindac	Anaprox [®] IR & DS [®] Advil [®] Aleve [®] Ansaïd [®] Arthrotec [®] Cataflam [®] *Celebrex [®] Clinoril [®] Daypro [®] diclofenac potassium diclofenac sodium SR diclofenac sodium/misoprostol diflunisal Dolobid [®] Duexis [®] etodolac IR & SR	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit plus A one-month trial of at least two preferred medications within the same class. *Step edit required for Celebrex[®] - History of a trial of a minimum of two (2) different non-COX2 NSAIDs within the past year, OR - Concurrent use of anticoagulants (i.e., warfarin, heparin, etc.), methotrexate, oral corticosteroids, OR - History of previous GI bleed or conditions associated with GI toxicity risk factors (i.e., PUD, GERD, etc.), OR specific indication for Celebrex[®], which medications not requiring Service Authorization are not indicated.



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		Feldene® fenoprofen flurbiprofen Indocin® IR & SR® indomethacin IR, SR & rectal ketoprofen IR & ER ketorolac Lodine® IR & XL meclofenamate mefenamic meloxicam susp Mobic® Motrin® Nalfon® Naprelan® Naprosyn® naproxen EC Orudis® Oruvail® oxaprozin Ponstel® Prevacid Naprapac® Relafen® Sprix® nasal spray Tolectin DS® Toradol® tolmetin sodium Vimovo® Voltaren® IR & XR Zipsor® Zorvolex™	
Topical Analgesic Agents and Anesthetics			
	*Flector® patch *Voltaren® gel	**Lidoderm® patch **lidocaine 5% patch *Pennsaid® top soln & pump ***Solaraze 3% Top Gel	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit <u>*Clinical Criteria for Topical Analgesic Agents and Anesthetics</u> ➤ <u>*Flector®, Voltaren® & Pennsaid®:</u>



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			- Approval is based on patient failing the oral generic of the desired product and at least one other preferred NSAID (to equal a total of at least two preferred). For example, a patient who failed ibuprofen or naproxen will still need to try oral generic diclofenac for approval of Flector®. - Pennsaid® can only be approved for the FDA approved indication of osteoarthritis of the knee. - Quantity limit for Flector® Patch; 30 patches per RX ➤ **Lidoderm® Patch: - Lidoderm® patches can be approved for relief of pain associated with post-herpetic neuralgia. ➤ ***Solaraze® 3% Gel Clinical Criteria: - Indicated for the topical treatment of actinic keratosis (AK). - Sun avoidance is indicated during therapy. - Precautions exist for patients with active GI ulceration or bleeding and severe renal or hepatic impairment
Antibiotic-Anti-Infective			
	Antibiotics, Inhaled		
	Tobi® *Tobi Podhaler®	Bethkis® Cayston® tobramycin inhalation nebulizer sol	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit plus Clinical Criteria for Antibiotics, Inhaled ➤ *Tobi Podhaler® (tobramycin inhalation powder) - Tobi® nebulizer 300mg/5 mL solution is covered without SA; clinical reason as to why Tobi® nebulizer 300mg/5 mL solution cannot be used. - Minimum age restriction of 6 years of age. ➤ Cayston® and Bethkis® - Diagnosis of cystic fibrosis - Previous therapy with tobramycin via nebulizer. - Demonstration of TOBI® compliance. Quantity limits Tobi® = 8 capsules per day Cayston® = 84mL per 28 days



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		Bethkis [®] = 56 ampules per 28 days
Antibiotics, Vaginal		
Cleocin [®] Ovules Metrogel [®] Vandazole [™] gel	Cleocin [®] cr Clindesse [®] cr clindamycin cr metronidazole gel	LENGTH OF AUTHORIZATIONS: Date of Service Routine PDL edit
Antifungals, Oral		
fluconazole tab/susp Griseofulvin [®] susp Gris-Peg [®] ketoconazole nystatin tab/susp terbinafine	*Ancobon [®] clotrimazole (mucous mem) Diflucan [®] tab/susp flucytosine Grifulvin V [®] tab griseofulvin tablets griseofulvin ultramicrosize itraconazole **Lamisil [®] tab/granules ***Noxafil [®] ****Onmel [®] *****Sporanox [®] cap/soln Terbinex [™] kit *****Vfend [®] tab/susp voriconazole tab & Powder for Susp	LENGTH OF AUTHORIZATIONS: Duration of the prescription (up to 12 months) Routine PDL edit plus Clinical Criteria for Antifungals, Oral ➤ Ancobon[®]: - Indicated for the treatment of : Candida: Septicemia, endocarditis, and UTIs Cryptococcus: meningitis, pulmonary infections - Can be approved if the patient has a serious illness that leaves them immunocompromised (i.e. AIDS, cancer, organ transplants). ➤ **Lamisil[®] granules - Indication is tinea capitis, AND - Must be over 4 years of age. ➤ *** Noxafil[®] - One of the following indications: - Used for preventative (prophylactic) therapy for treatment of invasive Aspergillus - Diagnosis of Candida - Patient is immunocompromised - Diagnosis of graft-versus-host disease (GVHD) - Patient has a hematologic malignancy (a cancer of the blood, bone marrow, or lymph nodes) - Patient has prolonged neutropenia from chemotherapy - Diagnosis of Zygomycosis - Diagnosis of Fusariosis - Patient has another fungal infection or mold infection is refractory or resistant to itraconazole or voriconazole, or patient has a contraindication to itraconazole or voriconazole



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			➤ ****Onmel[®] • Indicated for the treatment of onychomycosis of the toenail caused by <i>Trichophyton rubrum</i> or <i>T. mentagrophytes</i>. • Patient had a therapeutic trial and treatment failure with oral terbinafine, OR • Patient has a contraindication to oral terbinafine (i.e. heart failure, hepatic impairment, viral hepatitis). ➤ *****Sporanox[®] • indication are Aspergillosis, Candidiasis (oral or esophageal), Histoplasmosis, Blastomycosis, empiric treatment of febrile neutropenia ➤ *****Vfend[®]: • Can be approved without failure on the preferred agent if the patient has any of the following diagnoses: ○ Myelodysplastic Syndrome (MDS), ○ Neutropenic Acute Myeloid Leukemia (AML) ○ Graft versus Host Disease (GVHD) ○ Candidemia (candida krusei) ○ Esophageal Candidiasis ○ Pulmonary or invasive aspergillosis ○ Blastomycosis ○ Serious fungal infections caused by <i>Scedosporium apiospermum</i> (asexual form of <i>Pseudallescheria boydii</i>) and <i>Fusarium</i> spp., including <i>Fusarium solani</i>, in patients intolerant of, or refractory to other therapy. ○ Oropharyngeal/esophageal candidiasis refractory to fluconazole. • Can be approved if the patient has a serious illness that leaves them immunocompromised (i.e. AIDS, cancer, organ transplants).
Cephalosporins, Oral			
Second Generation Cephalosporins			LENGTH OF AUTHORIZATIONS: Date of service only; no refills Routine PDL edit plus Clinical Criteria for Cephalosporins • Infection caused by an organism resistant to medications not requiring SA • A therapeutic failure to no less than a three-day trial of one medication
cefaclor cap cefprozil cap/susp cefuroxime tab	cefaclor ER cefaclor susp Ceftin [®] tab/susp Cefzil [®] tab/susp		



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		within the same class not requiring SA The patient is completing a course of therapy with a medication requiring a SA, which was initiated in the hospital.
Third Generation Cephalosporins		
cefdinir cap/susp Suprax [®] tab/susp	Cedax [®] cap/susp ceftibuten cefditoren pivoxil cefpodoxime proxetil cap/susp Omnicef [®] cap/susp Spectracef [®] Suprax [®] chewable tab Suprax [®] cap	
Macrolides, Oral		
Macrolides & Ketolides		LENGTH OF AUTHORIZATIONS: Date of service only; no refills Routine PDL edit plus Clinical Criteria for Macrolides and Ketolides - Infection caused by an organism resistant to medications not requiring SA - A therapeutic failure to no less than a three-day trial of one medication within the same class not requiring SA - The patient is completing a course of therapy with a medication requiring a SA, which was initiated in the hospital *Generics are not available in some strengths/dosage forms **To receive a SA for Ketek[®], a specific Ketek[®] SA request form must be completed and faxed or mailed to Magellan Medicaid Administration with the prescriber's signature.
azithromycin pack/susp/tab clarithromycin tab/susp *E.E.S. [®] *EryC [®] *Eryped [®] 400 susp Ery-tab [®] erythrocin stearate erythromycin base erythromycin ethylsuccinate erythromycin estolate susp erythromycin stearate erythromycin/sulfisoxazole	Biaxin [®] tab/ susp/XL clarithromycin ER Dynabac [®] *Eryped [®] 200 susp erythromycin base DR cap **Ketek [®] PCE [®] Zithromax [®] pac/tab/susp ZMAX [®] susp	
Quinolones, Oral		
Second Generation Quinolones		LENGTH OF AUTHORIZATIONS: Date of service only; no refills Routine PDL edit plus: Clinical Criteria for Quinolones - Infection caused by an organism resistant to medications not requiring SA. - A therapeutic failure to no less than a three-day trial of one medication within the same class not requiring SA.
Cipro [®] susp ciprofloxacin tab	Cipro [®] IR & XR ciprofloxacin susp & ER Noroxin [®] ofloxacin Proquin XR [®]	



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			The patient is completing a course of therapy with a medication requiring a SA, which was initiated in the hospital.
Third Generation Quinolones			
Avelox [®] ABC PACK levofloxacin tab	Avelox [®] Factive [®] Levaquin [®] tab/susp levofloxacin susp moxifloxacin Proquin XR [®]		
Quinolones, Otic			
Ciprodex [®] ofloxacin	Cetraxal [®] Cipro HC [®]	<u>LENGTH OF AUTHORIZATIONS:</u> Date of service only; no refills Routine PDL edit	
Topical			
mupirocin ointment	*Altabax [™] Bactroban [®] cream/ointment Centany [®] Centany AT [®] Kit	<u>LENGTH OF AUTHORIZATIONS:</u> Date of service only; no refills Routine PDL edit *Quantity Limit = 15 grams per 34 days	
Antivirals			
Hepatitis C Agents			
Interferon		<u>LENGTH OF AUTHORIZATIONS:</u> refer to Clinical Criteria for each drug	
Peg-Intron [®] Peg-Intron Redipen [®]	Pegasys [®] Proclick/syringe/kit/vial	<u>Clinical Criteria for Interferon</u> <u>Initial 16 week SA:</u> Initial approval periods limited to 16-weeks and viral titer obtained at week 12 of therapy. <u>Established HCV reactors:</u> Therapy is approvable for a total of 24 weeks in patients that are HCV genotypes 2 or 3 who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV	



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		RNA titer from baseline) at 12 weeks of treatment. • Therapy is approvable for total of 48 weeks in HCV genotype 1 or 4 patients who have achieved a virologic response (either undetectable HCV RNA [<50 IU/mL] or at least a 2-log drop in HCV RNA titer from baseline) at 12 weeks of treatment. • If patient fails to achieve a virologic response by 12 weeks, further treatment is not indicated.
Protease Inhibitor		Clinical Criteria for Protease Inhibitors
*Incivek[®] **Victrelis[®]	***Olysio[™]	• *Incivek[®] (Triple Therapy) • Confirm diagnosis of HCV with genotype 1, AND concurrent therapy with ribavirin and peginterferon, AND no previous protease inhibitor treatment for Hep C. • At initial prescription fill, if above criteria are met – approve for 12 weeks. Lab work needs to be done at 4 weeks. • Course of telaprevir should <i>not</i> be repeated. • **Victrelis[®] (Triple Therapy) • Confirm diagnosis of HCV with genotype 1, AND no previous protease inhibitor treatment for Hep C, AND completed ribavirin and peginterferon for at least 4 weeks, AND concurrent therapy with ribavirin and peginterferon • Evaluate for the following conditions for longer duration of approval: ○ Cirrhosis – Approve for 44 weeks ○ Previous treatment with peginterferon and ribavirin with documented lack of achievement of > 2 log reduction at week 12 in previous treatment – Approve for 44 weeks. ○ If none of above in a or b, then evaluate below to determine duration of therapy. • At initial prescription fill, confirmed diagnosis of HCV with genotype 1 and completed 4 weeks of peginterferon and ribavirin with continuing therapy – approve for 24 weeks. • After 24 weeks – require labs drawn at weeks 8 and 24. Depending on the result – determine the duration of approval: ○ Treatment naïve patients: ▪ If week 8 and 24 are both undetectable – triple therapy is



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		completed. No further Victrelis® therapy. ▪ If week 8 results are detectable and week 24 results are undetectable – then approve Victrelis® for 8 more weeks. ▪ If week 24 results are detectable, discontinue all 3 therapies (Victrelis® and peginterferon/ribavirin). ○ Previously treated or relapsed patients: ▪ If week 8 and 24 are both undetectable – approve for 8 more weeks for Victrelis® and peginterferon/ribavirin (then discontinue all 3) ▪ If week 8 results are detectable and week 24 results are undetectable – then approve Victrelis for 8 more weeks. ▪ If week 24 results are detectable, discontinue all 3 therapies (Victrelis and peginterferon/ribavirin). • For ALL patients –If at week 12, the HCV-RNA level is > 100 IU/mL, do not approve Victrelis®. • For ALL patients - If at week 24 HCV-RNA results are detectable, discontinue all 3 therapies (Victrelis® and peginterferon/ribavirin). • Lab work needs to be done at 8, 12, and 24 weeks. ***Olysio™ (Triple Therapy) Initial Approval • Length of authorization: 8 weeks for all three agents • Prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease physician. • Diagnosis of hepatitis C virus (HCV) with genotype 1 showing fibrosis corresponding to a Metavir score of F3 or greater; AND • Patient CANNOT have failed therapy with an oral protease inhibitor indicated for HCV (e.g., Incivek®, Victrelis®, or Olysio®); AND • Must have concurrent (or planning to start) therapy with ribavirin and peginterferon when starting simeprevir; AND • Must be an adult patient age 18 and over; AND • Patient has NOT had liver transplant; AND • Patient is NOT infected with HCV genotype 1a containing the Q80K polymorphism; AND • Patient is NOT co-infected with HCV/HIV; AND • Patient is NOT receiving concomitant therapy with sofosbuvir (Sovaldi™).



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			• Patient must be evaluated for current history of substance abuse and alcohol with validated screening instruments. ***Olysio™ (Triple Therapy) Renewal Criteria • Confirmation the patient has been compliant with drug therapy regimen (per pharmacy paid claims history) • The prescriber can submit clinical rational for treatment continuation, for positive tests that are false positives and not thought to be due to a relapse in alcohol or substance abuse. ○ Test results will need to be submitted along with other lab work for renewals • A CLIA-certified laboratory should be used for ongoing lab monitoring. • After 8 weeks of therapy, approve simeprevir, peginterferon alfa and ribavirin for an additional 4 weeks of therapy if HCV-RNA is < 25 IU/mL at treatment week 4 (TW4). • After 8 weeks of therapy, discontinue simeprevir, peginterferon alfa, and ribavirin if HCV-RNA is ≥25 IU/mL at TW4.



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	Nucleotide Analog NS5B Polymerase Inhibitor	Clinical Criteria for Nucleotide Analog NS5B Polymerase Inhibitor
	Sovaldi®	➤ Sovaldi® Initial Approval - Length of authorization: 8 weeks - Must be prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease physician. - Genotypes 1, 2, 4 (triple therapy) – Treatment Week 8 (TW8) pending HCV RNA at TW4, then 4 additional weeks of therapy for a total duration of 12 weeks. - Genotypes 1 and 3 (dual therapy) – (TW8) Pending HCV RNA at TW4, then 8 additional weeks of therapy and (TW16) HCV RNA at TW12, then 8 additional weeks of therapy for a total duration of 24 weeks. - Up to 48 weeks in hepatocellular carcinoma if awaiting liver transplant Genotypes 1, 2, 3, 4 pre-transplant. - Adult patients age ≥18 years old. - Patient must be treatment naïve to sofosbuvir. - Patient is not receiving concomitant therapy with a hepatitis protease inhibitor (e.g., telaprevir [Incivek®], boceprevir [Victrelis®], simeprevir [Olysio®]). - Showing fibrosis corresponding to a Metavir score of F3 or greater. Diagnostic/Disease Severity Evidence (must be attached to request) - Patient must be evaluated for current history of substance abuse and alcohol with validated screening instruments ➤ Sovaldi® Renewal Criteria - Confirmation the patient has been compliant with drug therapy regimen (per pharmacy paid claims history). - The prescriber can submit clinical rational for treatment continuation, for positive tests that are false positives and not thought to be due to a relapse in alcohol or substance abuse. - Test results will need to be submitted along with other lab work for renewals - A CLIA-certified laboratory should be used for ongoing lab monitoring.
Herpes Oral		



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	acyclovir tab/susp famciclovir valacyclovir	<i>Famvir[®]</i> <i>Valtrex[®]</i> <i>Zovirax[®] tab/susp</i>	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit
Herpes Topical			
	Abreva OTC[®] Zovirax[®] ointment	<i>acyclovir oint</i> <i>Denavir[®]</i> <i>Xerese[®] cr</i> <i>Zovirax[®] cr</i>	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit
Influenza			
	amantadine tab/syrup Relenza Disk[®] rimantadine Tamiflu[®] cap/susp	<i>amantadine cap</i> <i>Flumadine[®] syrup/tab</i>	<u>LENGTH OF AUTHORIZATIONS:</u> Date of service only Routine PDL edit
Blood Modifiers			
	Berinert[®] (C1-inhibitor) Cinryze[™] (C1-inhibitor) Kalbitor[®] (kallikrein inhibitor)	<i>Firazyr[®] (icatibant)</i>	<u>LENGTH OF AUTHORIZATIONS:</u> Date of service (plus one additional supply for emergency use) Routine PDL edit plus <u>Clinical Criteria for Blood Modifiers</u> - Must be prescribed and under direct care by a board-certified allergist, immunologist or hematologist - For prophylaxis must have - HAE attacks occur at least once monthly - Disabled at least 5 days per month - History of attacks with airway compromise / hospitalization - History of Prior prophylaxis with danazol: - danazol contraindicated (pediatric, hepatic or renal impairment, pregnancy, breast-feeding, abnormal genital bleeding) - Developed danazol toxicity - Diminished danazol efficacy <u>FDA Indications and Quantity Limits</u> - Berinert[®] Acute abdominal, facial or laryngeal HAE attacks (20 U per kg) 500 units/ vial- 4 vials per attack (plus 4 for emergency) - Cinryze[™] Prevention of HAE attacks. Cinryze; 1,000 U - IV twice/week (500 units/vial) 20 vials per 34 days



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			- Kalbitor[®] Acute HAE attacks in patients 16 years of age and older. (3-10 mL per dose Health care person to administer) 1 dose (plus one for emergency) - Firazyr[®] Acute attacks of (HAE) in adults 18 years of age and older; 30mg/dose (plus one for emergency)
Bone Resorption Suppression and Related Agents			
Bisphosphonates			
	alendronate Fosamax[®] soln	Actonel [®] Actonel [®] with CA alendronate soln Atelvia DR [®] Boniva [®] Binosto [™] *Didronel [®] etidronate Fosamax [®] Fosamax [®] plus D ibandronate	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit *Indicated only for treatment of Paget's disease of bone OR prevention and treatment of heterotopic ossification following total hip replacement or spinal cord injury.
Calcitonins			
	Fortical[®]	calcitonin-salmon nasal Miacalcin[®]	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit
Others			
	Evista[®]	Forteo[®] raloxifene	<u>LENGTH OF AUTHORIZATIONS:</u> Initial approval will be for 1 year with ONE renewal if demonstrated compliance. Maximum duration of therapy is 24 months during a patient's lifetime. Routine PDL edit plus <u>Clinical Criteria for Forteo[®] (teriparatide)</u> - Treatment of osteoporosis in postmenopausal women who are at high risk for fracture. - Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures. - Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture.



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			• Bone mineral density of -3 or worse OR • Postmenopausal women with history of non-traumatic fracture(s) OR • Postmenopausal women with two or more of the following clinical risk factors: ○ Family history of non-traumatic fracture(s) ○ Patient history of non-traumatic fracture(s) ○ DXA BMD T-score $\leq$-2.5 at any site ○ Glucocorticoid use* ($\geq$6 months of use at 7.5 dose of prednisolone equivalent) ○ Rheumatoid Arthritis ○ Postmenopausal women with BMD T-score $\leq$-2.5 at any site with any of the following clinical risk factors: ▪ More than 2 units of alcohol per day ▪ Current smoker ▪ Men w/primary or hypogonadal osteoporosis ▪ Osteoporosis associated w/sustained systemic glucocorticoid therapy
Cardiac			
ACE Inhibitors, Angiotensin Receptors Blockers, Beta-Blockers			
ACE Inhibitors			LENGTH OF AUTHORIZATION: 1 year
benazepril captopril enalapril lisinopril ramipril	Accupril® Aceon® Altace® cap/tab Epaned™ soln fosinopril Lotensin® Mavik® moexipril Monopril® perindopril Prinivil® quinapril ramipril trandolapril Univasc®		Routine PDL edit



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	Vasotec [®] Zestril [®]	
ACE Inhibitors + Calcium Channel Blocker Combinations		
amlodipine/benazepril	Lotrel [®] Tarka [®] trandolapril/verapamil hydrochloride ER	
ACE Inhibitors + Diuretic Combinations		
benazepril/HCTZ captopril/HCTZ lisinopril/HCTZ	Accuretic [®] enalapril/HCTZ fosinopril/HCTZ Lotensin HCT [®] moexipril/HCTZ Prinzide [®] quinapril/HCTZ Uniretic [®] Univasc [®] Vaseretic [®] Zestoretic [®]	
Angiotensin Receptor Blockers		
*Diovan [®] losartan	Atacand [®] Avapro [®] Benicar [®] candesartan Cozaar [®] Edarbi [®] eprosartan mesylate irbesartan Micardis [®] telmisartan/HCTZ Teveten [®]	*Step edit requires a trial and failure of losartan



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Angiotensin Receptor Blockers + Calcium Channel Blocker Combinations			
		Azor [®] Exforge [®] Exforge [®] HCT Tribenzor [®]	
Angiotensin Receptor Blockers + Diuretic Combinations			
losartan/HCTZ **valsartan/HCTZ		Atacand HCT [®] Avalide [®] Benicar HCT [®] candesartan/HCTZ Diovan HCT [®] Edarbyclor [®] Hyzaar [®] irbesartan/HCTZ Micardis HCT [®] Teveten HCT [®]	**Step edit requires a trial and failure of losartan/HCTZ
Beta Blockers			
atenolol carvedilol labetalol metoprolol tartrate nadolol propranolol tab/soln Sorine [®] sotalol AF sotalol HCL		acebutaolol Betapace [®] IR & AF [®] betaxolol bisoprolol Bystolic [®] Coreg [®] IR & CR [®] Corgard [®] Inderal [®] XL Innopran [®] XL Kerlone [®] Levator [®] Lopressor [®] metoprolol succinate pindolol propranolol LA Sectral [®] Tenormin [®] timolol maleate Toprol XL [®]	



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		Trandate [®] Zebeta [®]	
Beta Blockers + Diuretic Combinations			
atenolol/chlorthalidone bisoprolol/HCTZ nadolol/bendroflume - thiazide propranolol/HCTZ		Corzide [®] Dutoprol [®] Inderide [®] Lopressor HCT [®] metoprolol/HCTZ Tenoretic [®] Ziac [®]	
Direct Renin Inhibitors (includes combination)			
		Amturnide [™] Tekamlo [®] Tekturna [®] Tekturna HCT [®] Twynsta [®] telmisartan/amlodipine Valturna [®]	
Anticoagulants			
Low Molecular Weight Heparin includes FactorXA Inhibitor			LENGTH OF AUTHORIZATIONS: 1 year
Fragmin [®] Syringe Lovenox [®]		Arixtra [®] enoxaparin fondaparinux Fragmin [®] vial Innohep [®]	Routine PDL edit plus
Oral Anticoagulants			*Clinical Criteria for Anticoagulant, Oral
warfarin *Pradaxa [®] **Xarelto [®]		Coumadin [®] ***Eliquis [™]	➤ *Pradaxa - May be approved for the following diagnosis - To reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation OR - For the treatment of deep venous thrombosis (DVT) and pulmonary embolism (PE) in patients who have been treated with a parenteral anticoagulant for 5-10 days OR - To reduce the risk of recurrence of DVT and PE in patients who have been previously treated



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Preferred Agents		Non-Preferred Agents	SA Criteria
			➤ ** <u>Xarelto® (rivaroxaban)</u> - May be approved for the following diagnosis - Nonvalvular atrial fibrillation - Treatment of deep vein thrombosis (DVT) or - Pulmonary embolism (PE), or - For the reduction in the risk of recurrence of DVT and of PE for the prophylaxis of DVT, in patients undergoing knee or hip replacement surgery ➤ *** <u>Eliquis™</u> - May be approved for the following diagnosis: - Reduction in risk of stroke and systemic embolism in nonvalvular atrial fibrillation - Prophylaxis of DVT following hip or knee replacement surgery
Calcium Channel Blockers: Dihydropyridine CCB & Non-Dihydropyridine CCB			
Dihydropyridine Calcium Channel Blockers			LENGTH OF AUTHORIZATIONS: 1 year
Afeditab CR® amlodipine Nifediac CC® Nifedical XL® nifedipine nifedipine ER nifedipine SA	Adalat® Adalat CC® Cardene® Cardene SR® Dynacirc® IR & CR® felodipine ER isradipine nisoldipine nicardipine Norvasc® Procardia® Procardia XL® Plendil® Sular®		Routine PDL edit
Non-Dihydropyridine Calcium Channel Blockers			
Cartia XT® Diltia XT® diltiazem IR, ER q 12 hr & 24 hr	Calan® IR & SR Cardizem® IR, CD & LA Dilacor XR® diltiazem SR q 12hr		



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Preferred Agents		Non-Preferred Agents	SA Criteria
	diltiazem XR Taztia XT[®] verapamil tab IR & ER	<i>Isoptin SR[®]</i> <i>Tiazac[®]</i> <i>verapamil ER cap</i> <i>Verelan[®]</i> <i>Verelan PM[®]</i>	
Lipotropics			
Bile Acid Sequestrants			LENGTH OF AUTHORIZATIONS: 1 year
cholestyramine powder reg & light colestipol tab Prevalite[®] Welchol[®] tab	<i>Colestid[®] granule/packet/tab</i> <i>colestipol HCl granules</i> <i>Questran[®] powder/powder</i> <i>Light</i> <i>Welchol[®] packet</i>		Routine PDL edit plus
Cholesterol Absorption Inhibitor (CAI)			Therapeutic failure to no less than three-month trial of at least one medication not requiring SA.
Zetia[®]			
Fibric Acid Derivatives			
gemfibrozil Tricor[®]	<i>Antara[®]</i> <i>fenofibrate (Tricor[®])</i> <i>fenofibrate (Antara[®])</i> <i>fenofibrate (Lipofen[®])</i> <i>fenofibric acid</i> <i>Fenoglide[®]</i> <i>Lipofen[®]</i> <i>Lofibra[®]</i> <i>Lopid[®]</i> <i>Triglide[®]</i> <i>Trilipix[™]</i>		
HMG CoA Reductase Inhibitors and Combinations (High Potency Statins)			
atorvastatin simvastatin	<i>amlodipine/atorvastatin</i> <i>Caduet[®]</i> <i>Crestor[®]</i> <i>Lipitor[®]</i> <i>Livalo[®]</i> <i>Vytorin[®]</i> <i>Zocor[®]</i>		



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HMG CoA Reductase Inhibitors and Combinations (Statins)			
lovastatin pravastatin		Advicor [®] Altoprev [®] fluvastatin Lescol [®] Lescol XL [®] Mevacor [®] Pravachol [®]	
Microsomal Triglyceride Transfer Protein Inhibitor			Clinical Criteria for Lipotropics, Other
		**Juxtapid [™]	➤ **Juxtapid[™] • Diagnosis of homozygous familial hypercholesterolemia (HoFH). • Prescriber must be certified with the Juxtapid[™] REMS program. • Minimum age restriction of 18 years of age. • Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants.
Niacin Derivatives			
Niacor [®] Niaspan [®]		niacin ER	
Niacin Derivatives & HMG CoA Reductase Inhibitors Combination			
		*Simcor [®]	
Omega 3 Fatty Acid Agent			➤ ***Lovaza[®] • Step edit requires trial and failure of any other lipotropic. • A SA may also be approved without a documented medication trial if patient has documented high triglycerides of ≥ 500 mg/dL.
		**Lovaza [®] omega-3 acid ethyl esters	
Oligonucleotide Inhibitor			****Kynamro[™] • Diagnosis of homozygous familial hypercholesterolemia (HoFH). • Prescriber must be certified with the Kynamro[™] REMS program. • Minimum age restriction of 18 years of age. • Patient has had treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents, and bile acid sequestrants
		****Kynamro [™]	



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Platelet Inhibitors			
clopidogrel dipyridamole Effient® ticlopidine HCL	Aggrenox® Brilinta® Persantine® Plavix®		LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Pulmonary Arterial Hypertension Agents			
Inhaled Prostacyclin Analogues			LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Tyvaso® Ventavis®			
Oral Endothelin Receptor Antagonist			
Letairis® Tracleer®	Opsumit®		
Phosphodiesterase 5 Inhibitors			*Clinical Criteria for PDE-5
*sildenafil	*Adcirca™ *Revatio® oral *Revatio® injection		• Diagnosis of pulmonary hypertension in patients >18 years is required. • The requested medication may be approved if the following is true: ○ The prescriber is a pulmonary specialist or cardiologist and will be followed by the prescribing physician. • Must have a rationale for not taking the oral Revatio® to receive a SA for the injectable Revatio®. • PDE-5 contraindications where SA should not be approved: ○ Concurrent use of nitrates (e.g., nitroglycerin) ○ Hypersensitivity to product
Prostacyclin Vasodilator			
	Orenitram™		
Soluble Guanylate Cyclase Stimulators			
	Adempas®		
Central Nervous System			
Alzheimer's Agents			
Cholinesterase Inhibitors			LENGTH OF AUTHORIZATIONS: Length of prescription (up to 3 months)
donepezil tab Exelon® (transderm)	Aricept® ODT, tab & 23 mg tab donepezil ODT & 23mg tab Exelon® cap & soln galantamine IR, ER tab & soln Razadyne® IR, ER rivastigmine cap		Routine PDL edit



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NMDA Receptor Antagonist			When Namenda [®] tablet is not available, Namenda [®] XR will be preferred.
Namenda [®] soln/tab		Namenda [®] Dose Pack & XR Tab	
Antimigraine Agents			
Relpax [®] sumatriptan succinate tab/cartridge/nasal/vial/ pen rizatriptan tab & MLT		Alsuma [®] Amerge [®] Axert [®] Cambia [®] Frova [®] Imitrex [®] cartridge/ nasal/pen/tab/vial Maxalt [®] tab & MLT naratriptan Sumavel [®] Dosepro Treximet [®] Zomig [®] tab/nasal spray/ZMT	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Non-Ergot Dopamine Receptor Agonist			
pramipexole ropinirole HCl		Mirapex [®] IR & ER Neupro [®] Requip [®] IR & XR ropinirole HCl ER	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Sedatives / Hypnotics			
chloral hydrate syrup flurazepam temazepam 15 & 30 mg		Doral [®] estazolam Halcion [®] Restoril [®] temazepam 7.5 mg & 22.5 mg triazolam	LENGTH OF AUTHORIZATIONS: Length of the prescription (up to 3 months) Routine PDL edit plus
Sedatives / Hypnotics (Non-Benzodiazepine)			Clinical Criteria for *Hetlioz[™]
Rozerem [®] zolpidem		Ambien [®] IR & CR Edluar [™] eszopiclone *Hetlioz [™] Intermezzo [®] Lunesta [®] Silenor [®] Somnote [®]	Length of Authorization: 6 months. For Renewal - must document therapeutic benefit and confirm compliance - For the treatment of Non-24-Hour Sleep-Wake Disorder (Non-24). - The patient is completely blind. - Patient must be age 18 years of age or older - Quantity limit = 1 tablet per day



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Preferred Agents		Non-Preferred Agents	SA Criteria
		Sonata [®] Zaleplon [®] zolpidem CR Zolpimist [™] spray	
Skeletal Muscle Relaxants			
baclofen chlorzoxazone cyclobenzaprine HCL dantrolene sodium methocarbamol tizanidine tab	Amrix [®] *carisoprodol *carisoprodol/ASA *carisoprodol/ASA/codeine cyclobenzaprine ER Dantrium [®] Fexmid [®] Flexeril [®] Lorzone [®] metaxalone Norflex [®] orphenadrine citrate orphenadrine/ASA/caffeine Parafon Forte [®] DSC Robaxin [®] Skelaxin [®] *Soma [®] tizanidine cap Zanaflex [®]	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year for chronic conditions - Duration of prescription (up to 3 months) for acute conditions - One month per every 6 months carisoprodol products Routine PDL edit plus <u>*Clinical Criteria for carisoprodol products</u> - The patient is at least 16 years of age. - Only approve for ACUTE, painful musculoskeletal conditions. Do not approve for chronic pain. - Quantity limit = 4 tablets per day - Limit approval to one month supply (120 tablets) - Additional authorization will not be granted for at least 6 months following the last day of the previous course of therapy.	
Smoking Cessation			
bupropion SR Chantix [®] Chantix [®] Tab DS PK nicotine gum/ lozenge/ patch	Nicoderm CQ [®] Patch Nicorette [®] Gum/Lozenges Nicotrol [®] Inhaler & NS Zyban [®]	<u>LENGTH OF AUTHORIZATIONS:</u> 6 months Routine PDL edit	
Stimulants/ADHD Medications			
Amphetamine Products		<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit plus	
Adderall [®] XR amphetamine salts combo dextroamphetamine Vyvanse [®]	Adderall [®] IR amphetamine salts combo XR Desoxyn [®] Dexedrine [®]	<u>Step Edit for</u> Adderall XR [®] If a trial & failure of a preferred product occurs and the physician requests	



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Preferred Agents	Non-Preferred Agents	SA Criteria														
	dextroamphetamine SR & Sol Dextrostat [®] methamphetamine Procentra [®] soln Zenzedi [™]	Adderall XR [®] or amphetamine salts combo XR. The brand Adderall XR [®] is preferred over the generic. ** <u>Clinical Criteria for all Stimulants/ADHD products</u> Length of Authorization: 1 year Each product listed below will require an SA for ages less than the FDA/PI indicated age. <table><tr><th>Brand name</th><th>PI age less than</th></tr><tr><td>Extended-release once-daily products; e.g., Adderall XR, Metadate CD, Concerta[®] Ritalin LA[®] etc.</td><td>6 years</td></tr><tr><td>Focalin XR[®]</td><td>6 years</td></tr><tr><td>Intuniv[®]</td><td>4 years</td></tr><tr><td>Immediate release formulations: e.g.,methylphenidate</td><td>3 years</td></tr><tr><td>Kapvay[®] SR</td><td>6 years</td></tr><tr><td>Strattera[®]</td><td>6 years</td></tr></table>	Brand name	PI age less than	Extended-release once-daily products; e.g., Adderall XR, Metadate CD, Concerta [®] Ritalin LA [®] etc.	6 years	Focalin XR [®]	6 years	Intuniv [®]	4 years	Immediate release formulations: e.g.,methylphenidate	3 years	Kapvay [®] SR	6 years	Strattera [®]	6 years
Brand name	PI age less than															
Extended-release once-daily products; e.g., Adderall XR, Metadate CD, Concerta [®] Ritalin LA [®] etc.	6 years															
Focalin XR [®]	6 years															
Intuniv [®]	4 years															
Immediate release formulations: e.g.,methylphenidate	3 years															
Kapvay [®] SR	6 years															
Strattera [®]	6 years															
Methylphenidate Products																
Focalin XR[®] All methylphenidate generic IR tablets methylphenidate SR	Concerta [®] Daytrana [®] dexmethylphenidate IR & XR Focalin [®] Metadate CD [®] Metadate ER [®] Methylin ER [®] Methylin chew [®] Methylin [®] soln methylphenidate soln methylphenidate LA Ritalin [®] Ritalin LA [®] Ritalin SR [®] ***Quillivant [™] XR 25 mg/5 mL susp	 														



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Preferred Agents		Non-Preferred Agents	SA Criteria
		****Provigil [®]	- Requires documentation that C-PAP has been maximized. Narcolepsy: Documentation of diagnosis via sleep study. Shift Work Sleep disorder: ONLY APPROVABLE FOR 6 MONTHS, work schedule must be verified and documented. Shift work is defined as working the all night shift. - Minimum age of 16 years for <u>Provigil[®]</u> - Minimum age of 17 years for <u>Nuvigil[™]</u>
Dermatologic			
Dermatologic Agents			
Combination Benzoyl Peroxide & Clindamycin for Acne		LENGTH OF AUTHORIZATIONS: 1 year	
benzoyl peroxide wash/cream/gel/lotion (OTC) clindamycin phosphate gel/lotion/soln Panoxyl-4 Acne Creamy Wash OTC	<i>Acanya[™] w/pump</i> <i>Acne Clearing System[®] OTC</i> <i>Azelex[®]</i> <i>Benzaclin[®]</i> <i>Benzefoam[™] regualr & Ultra[™]</i> <i>Benzepro</i> <i>benzoyl peroxide wash/cream/gel/lotion/foam/towelette (RX)</i> <i>benzoyl peroxide 6% cleanser OTC</i> <i>BPO Kit</i> <i>Cleocin T[®]</i> <i>Clindacin[™] Pac Kit</i> <i>Clindagel[®]</i> <i>clindamycin / benzoyl peroxide (Benzaclin) & (Duac)generics</i> <i>clindamycin phosphate foam/lotion/med.swab</i> <i>Delos Lotion[™]</i> <i>Duac[®] gel</i> <i>Evoclin[™]</i> <i>Inova[™]</i> <i>Lavoclen[™] Cleanser & Kit</i> <i>Pacnex[®] HP & LP</i> <i>Se BPO 7-5.5% Wash Kit</i>	Routine PDL edit plus Failure to respond to a therapeutic trial of at least two weeks of one preferred medication. Clinical Criteria for Dermatologic Acne Agents - Prescriptions for patients over the age of 18 years will require a SA to determine diagnosis for treatment. - Products are intended for acne only; a SA for a cosmetic indication cannot be approved	



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		Se BPO Cleanser	
	Topical Agents for Psoriasis		
	Dovonex[®] calcipotriene solu	anthralin calcipotriene cr/oint Calcitrene [®] calcitriol Dovonex [®] Scalp Micanol [®] Sorilux [™] Taclonex [®] Taclonex [®] Scalp Vectical	
	Topical Retinoids/Combinations for Acne		Clinical Criteria for Fabior[™] Foam
	Differin[®] tretinoin	adapalene 0.1% cream /gel Altinac [®] Atralin Avita [®] cream / gel Epiduo [®] Fabior [™] Foam Retin [®] A cream/gel Retin [®] -A Micro gel &Pump Tazorac [®] Tretin [®] -X tretinoin microsphere gel & gel pump Ziana [®]	• Patient between the ages of 12 and 18 years of age • All prescriptions for patients over the age of 18 years will require a SA to determine diagnosis for treatment. • Products are intended for acne only; a SA for a cosmetic indication cannot be approved.
Endocrine and Metabolic Agents			
	Androgenic Agents (Testosterone – Topical)		
	Androgel[®]	Androderm [®] Axiron [®] soln Fortesta [®] Testim [®]	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit plus Failure to respond to a therapeutic trial of at least one week of one preferred medication



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Preferred Agents	Non-Preferred Agents	SA Criteria
Antihyperuricemics		
allopurinol Probenecid [®] probenecid & colchicine	*Colcrys [®] Uloric [®] Zyloprim [®]	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit *Clinical Criteria for Colcrys[™] • Diagnosis of Familial Mediterranean Fever; OR • For Acute Gout Flare: ○ Trial and failure of one of the following: ▪ NSAID or ▪ Corticosteroid
Contraceptives		
Etonogestrel/Ethinyl Estradiol Vaginal Ring		LENGTH OF AUTHORIZATIONS: 1 year
NuvaRing [®]		Routine PDL edit
Norelgestromin/Ethinyl Estradiol Transdermal		
Ortho Evra [®]		
Oral Contraceptives		
Apri [®] Cryselle [™] Enpresse [®] Femcon Fe [®] Junel Fe [®] Loestrin [®] Loestrin Fe [®] Microgestin [®] Microgestin Fe [®] Mircette [®] Micronor [®] Norinyl 1+50 [®] Nor-Q-D [®] Nortrel [®] Ortho-Novum [®] Ortho Tri-Cyclen [®] Ortho Tri-Cyclen Lo [®] Ovcon [®] -50 Sprintec [®]	All other oral contraceptives	



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Preferred Agents	Non-Preferred Agents	SA Criteria
Tri-Sprintec [®] Trivora-28 [®] Yasmin [®] 28 Yaz [®] Zovia [®] 1-35E & 1-50E		
Diabetes Hypoglycemics: Injectable Amylin Analogs		
	*SymLin [®] *SymLin [®] Pens	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year *Clinical Criteria for Injectable Amylin Analogs • Patient must have a history of at least a 90 day trial of insulin. • SymLin[®] is only indicated as adjunct therapy with insulin. • Patient meeting ALL of the following criteria may be approved: ○ Diagnosis of Type 1 or 2 diabetes ○ On insulin therapy ○ Failure to achieve adequate glycemic control (HbA1c ≤ 6.5%)
Diabetes Hypoglycemics: Injectable Incretin Mimetics		
Byetta [®]	Bydureon [™] Victoza [®]	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit
Diabetes Hypoglycemics: Injectable Insulins		
Insulin Mix		<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit
Humalog [®] Mix 50/50 vial Humalog [®] Mix 75/25 vial Humulin [®] 70/30 vial Novolog [®] Mix 70/30 pen/ vial	Humalog [®] Mix 50/50 Kwikpen Humalog [®] Mix 75/25 Kwikpen Humulin [®] 70/30 pen (OTC) Novolin [®] 70/30 vial (OTC)	
Insulin N		
Humulin [®] N vial (OTC)	Humulin [®] N pen Novolin [®] N vial (OTC)	
Insulin R		
Humulin [®] R vial	Novolin [®] R vial (OTC)	



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Preferred Agents		Non-Preferred Agents	SA Criteria
Long-Acting Insulins			
Lantus [®] vial		Lantus Solostar [®] /cartridge	
Levemir [®] pen/vial			
Rapid-Acting Insulins			
Humulin 500 U/M vial		Apidra [®] cartridge/Solostar/vial	
Humalog [®] vial		Humalog [®] Cartridge	
Novolog [®] cartridge/ Flexpen/vial		Humalog Kwikpen [®]	
Diabetes Oral Hypoglycemics			
Oral Hypoglycemics Alpha-Glucosidase Inhibitors			LENGTH OF AUTHORIZATIONS: 1 year
acarbose		Precose [®]	Routine PDL edit
Glyset [®]			
Oral Hypoglycemics Biguanides			
metformin		Fortamet [®]	
metformin ER (generic for Glucophage [®] XR)		Glucophage [®] IR & XR Glutmetza [®] Riomet [®] susp metformin ER (generic for (Fortamet [®]))	
Oral Hypoglycemics Biguanide Combination Products			
glyburide/metformin		glipizide/metformin Glucovance [®] Metaglip [®]	
Oral Hypoglycemics DPP-IV Inhibitors and Combination			
Janumet [®]		Juvisync [™]	
Janumet XR [®]		Kazano [™]	
Januvia [®]		Kombiglyze XR [™]	
Jentadueto [™]		Nesina [™]	
Tradjenta [™]		Onglyza [™]	
		Oseni [™]	
Oral Hypoglycemics Meglitinides			
Starlix [®]		nateglinide	
		Prandin [®]	
		PrandiMet [™]	



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Oral Hypoglycemics Second Generation Sulfonylureas			
glimepiride glipizide glipizide ER glyburide glyburide micronized		Amaryl [®] Diabeta [®] Glucotrol [®] Glucotrol XL [®] Glynase [®]	
Oral Hypoglycemics Sodium Glucose Co-Transporter 2 Inhibitor (SGLT2)			Clinical Criteria for Oral Hypoglycemics: Sodium Glucose Co-Transporter 2 Inhibitor (SGLT2) Initial criteria for approval for 6 months. Renewals for 1 year. • Approve for Type 2 diabetics who have been compliant with and have not achieved adequate glycemic control with metformin, OR are intolerant to metformin. • Minimum age restriction of 18 years of age • Quantity limit = 1 tablet per day
		Farxiga TM Invokana TM	
Oral Hypoglycemics Thiazolidinediones			
pioglitazone		Avandia [®] Actoplus Met [®] IR & XR Actos [®] Avandaryl [®] Avandamet [®] Duetact [®] pioglitazone/metformin	
Erythropoiesis Stimulating Proteins: Epogen[®], Procrit[®] (Erythropoietin) & Aranesp[®] (Darbepoetin)			
Procrit [®]		Aranesp [®] Epogen [®]	LENGTH OF AUTHORIZATIONS: for duration of the prescription up to 6 months Routine PDL edit <i>Omontys[®] is not PDL eligible, may be covered under medical benefit</i>
Growth Hormone			
Genotropin [®] Nutropin AQ [®] NuSpin TM		Humatrope [®] cartridge/vial Norditropin cartridge [®] Norditropin FlexPro [®] & Nordiflex [®] Nutropin [®]	LENGTH OF AUTHORIZATIONS: 1 year Clinical Criteria for PEDIATRIC Patients (18 years of age and under) • Prescriber is an endocrinologist, nephrologist, infectious disease specialist or HIV specialist or one has been consulted on this case,



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	Nutropin AQ [®] cartridge/vial Omnitrope [®] Saizen [®] cartridge/vial *Serostim [®] Tev-Tropin [®] **Zorbtive [®]	• The patient has open epiphysis and one of the following diagnoses ○ Turner Syndrome ○ Prader-Willi Syndrome ○ Renal insufficiency ○ Small for gestational age (SGA) - including Russell-Silver variant and patient is < 2 years old ○ Idiopathic Short Stature (for request for renewal only (a) information is required to be approved) ○ Growth hormone deficiency (physician should provide the required information below) ○ Newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism. • Height is more than 2 SD (standard deviations) below average for the population mean height for age and sex, and a height velocity measured over one year to be 1 SD below the mean for chronological age, or for children over two years of age, a decrease in height SD of more than 0.5 over one year; AND • Growth hormone response of less than 10ng/mL to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine, or glucagon <u>Clinical Criteria for Renewal (pediatrics):</u> • For renewal, a response must be documented. Patient must demonstrate improved/normalized growth velocity. (Growth velocity has increased by at least 2 cm in the first year and is greater than 2.5 cm per year), AND • Patient height is more than 1 standard deviation (2”) below mid-parental height (unless parental height is diminished due to medical or nutritional reasons). <u>Clinical Criteria for ADULTS (> 18 years of age)</u> • Prescriber is an endocrinologist • Diagnosis of growth hormone deficiency confirmed by growth hormone stimulation tests and rule-out of other hormonal deficiency, as follows: growth hormone response of fewer than five nanograms per mL to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine or glucagon when measured by polyclonal antibody (RIA) or fewer than 2.5 nanograms per mL when



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		measured by monoclonal antibody (IRMA); - Cause of growth hormone deficiency is Adult Onset Growth Hormone Deficiency (AO-GHD), alone or with multiple hormone deficiencies, such as hypopituitarism, as a result of hypothalamic or pituitary disease, radiation therapy, surgery or trauma - Other hormonal deficiencies (thyroid, cortisol or sex steroids) have been ruled out or stimulation testing would not produce a clinical response such as in a diagnosis of panhypopituitarism. *Serostim[®] - Diagnosis of AIDS wasting or cachexia - Has a documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace[®] & Marinol[®]) *Length of Authorization: 3 months initial; then 1 year. Renewal is contingent upon improvement in lean body mass or weight measurements. **Zorbitive[®] - Diagnosis of short bowel syndrome
Progestational Agents		
medroxyprogesterone acetate (tablet only) norethindrone acetate progesterone injection Prometrium[®]	Aygestin [®] progesterone cap Provera[®]	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit plus Failure to respond to a therapeutic trial of at least one week of one preferred product.
Progestins Used For Cachexia		
megestrol acetate	Megace [®] Megace [®] ES	LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit
Vaginal/Oral Estrogens		
Premarin [®] Vaginal cr Vagifem [®] Vaginal tab	Estrace [®] Vaginal cr Estring [®] Vaginal ring Femring [®] Vaginal ring Osphena[®] tab	LENGTH OF AUTHORIZATIONS: 6 months Routine PDL edit



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Gastrointestinal		
Antiemetic/Antivertigo Agents (potential new class never reviewed)		
Cannabinoids (delta-9THC derivatives)		LENGTH OF AUTHORIZATIONS: 6 months
Marinol®	*Cesamet® **dronabinol	Routine PDL edit plus Clinical Criteria for Cannabinoids ➤ *Cesamet® • Diagnosis of severe, chemotherapy induced nausea and vomiting • Patient has tried and failed, has a contraindication to, an intolerance, or a medical reason not to try the combination of Emend® plus a 5HT3 receptor antagonist plus a corticosteroid. • Patient has tried and failed megestrol acetate oral suspension OR has a contraindication, intolerance, drug-drug interaction, or medical reason megestrol acetate cannot be used. ➤ **Dronabinol • Diagnosis of severe, chemotherapy induced nausea and vomiting • Patient has tried and failed, has a contraindication to, an intolerance, or a medical reason not to try the combination of Emend® plus a 5HT3 receptor antagonist plus a corticosteroid • Diagnosis of AIDS-relating wasting Patient has tried and failed megestrol acetate oral suspension OR has a contraindication, intolerance, drug-drug interaction, or medical reason megestrol acetate cannot be used.
5HT3 Receptor Blockers		LENGTH OF AUTHORIZATIONS: 3 months, unless otherwise noted
ondansetron ODT/tab	*Anzemet® *granisetron *Granisol® soln/tab *Kytril® ondansetron soln *Sancuso® patch Zofran®ODT/soln/tab *Zuplenz® film	Routine PDL edit plus * Clinical Criteria for 5HT3 Receptor Blockers: • Nausea or vomiting related to radiation therapy, moderate to highly emetogenic chemotherapy, or post-operative nausea and vomiting. • Patient has tried and failed therapeutic doses of, or has adverse effects or contraindications to, 2 different conventional antiemetics (e.g.,



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			promethazine, prochlorperazine, meclizine, metoclopramide, dexamethasone, etc.)
	NK-1 Receptor Antagoni		LENGTH OF AUTHORIZATIONS: Length of chemotherapy regimen or a maximum of 6 months
		** <i>Emend®</i> Bi Pak ** <i>Emend®</i> Tri-fold pack	Routine PDL edit plus Clinical Criteria for NK-1 Receptor Antagonist ➤ **<i>Emend®</i> (aprepitant) Emend® does NOT require treatment failure with preferred drugs when used for moderately or highly emetogenic chemotherapy. Quantity limits: One Emend® BiPack (2-80mg tablets) per chemotherapy treatment or, One Emend® TriPack (1-125mg tablet and 2-80mg tablets) per chemotherapy treatment.
	Other		LENGTH OF AUTHORIZATIONS: 1 year, unless other wise noted
	meclizine metoclopramide ondansetron tab & ODT prochlorperazine **promethazine	<i>Antivert®</i> <i>Compazine®</i> supp <i>Compro®</i> <i>*Diclegis®</i> <i>Dramamine®</i> <i>dimenhydrinate</i> <i>hydroxyzine</i> <i>Metozolv®</i> ODT ** <i>Phenergan®</i> <i>prochlorperazine</i> supp <i>Reglan®</i> <i>Tigan®</i> *** <i>Transderm-Scop®</i> <i>trimethobenzamide</i> <i>Vistaril®</i>	Routine PDL edit plus Clinical Criteria for Antiemetics/Antivertigo, Other ➤ *<i>Diclegis®</i> (doxylamine/pyridoxine) - Patient must be pregnant ➤ **<i>Promethazine</i> - Patient must be 2 years or older ➤ ***<i>Transderm-Scop®</i> may be approved for 3 months if: - Tried and failed at least one of the following: meclizine, promethazine, dimenhydrinate, diphenhydramine, or metoclopramide; OR - is unable to swallow or absorb oral medications - will be in an area/situation for an extended period of time where taking short acting agents would not be feasible
	Bile Salts		
	ursodiol 300 mg cap	<i>Actigal®</i>	LENGTH OF AUTHORIZATIONS: 1 year



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		Chenodal [®] ursodiol tab Urso [®] Urso [®] Forte tab	Routine PDL edit
H. Pylori Treatment			
Helidac [®] Pylera [®] Prevpac [®]		Omeclamox [®] -Pak lansoprazole/amoxicillin/clarithromycin	<u>LENGTH OF AUTHORIZATIONS:</u> 14 days Routine PDL edit
Histamine-2 Receptor Antagonists (H-2 RA)			
famotidine (OTC & RX) ranitidine tab/syrup (OTC & RX)		Axid [®] cap/soln (OTC/RX) cimetidine tab/syrup (OTC/RX) famotidine oral susp (OTC/RX) nizatidine cap/susp Pepcid [®] susp/tab (OTC/RX) ranitidine cap (OTC/RX) Tagamet [®] (OTC/ RX) Zantac [®] syrup/ tab (OTC/RX)	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit
Irritable Bowel Syndrome			
*Amitiza [®]		**Linzess [™] ***Lotronex [®]	<u>LENGTH OF AUTHORIZATIONS:</u> 6 months Routine PDL edit plus <u>Clinical Criteria</u> ➤ *Amitiza [®] • Must be 18 or older and • have one of the following diagnoses 1. Idiopathic Constipation with treatment failure of at least ONE product from TWO of the following classes: ○ Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol) ○ Bulk Forming Laxatives (examples: Metamucil[®] (psyllium), Citrucel[®], fiber) ○ Stimulant Laxatives (examples: bisacodyl, senna) 2. Constipation Predominant Irritable Bowel Syndrome (IBS-C) ○ Patient is female; AND



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		○ Treatment failure on at least ONE product from TWO of the following classes: ○ Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol) ○ Bulk Forming Laxatives (examples: Metamucil[®] (psyllium), Citrucel[®], fiber) ○ Stimulant Laxatives (examples: bisacodyl, senna) 3. Opioid Induced Constipation in chronic NON-cancer pain ○ Patient has tried and failed both PEG (i.e., Miralax[®]) AND lactulose ** > **Linzess[®] • Diagnosis of Idiopathic Chronic Constipation or Constipation-Predominant Irritable Bowel Syndrome (IBS) • Patient must be at least 6 years of age; AND • Treatment failure on at least ONE agent from TWO of the following classes: ○ Osmotic Laxatives (examples: lactulose, polyethylene glycol (PEG), sorbitol) ○ Bulk Forming Laxatives (examples: Metamucil[®] (psyllium), Citrucel[®], fiber) ○ Stimulant Laxatives (examples: bisacodyl, senna) ***Lotronex[®] • Diagnosis of severe, diarrhea predominant Irritable Bowel Syndrome • Patient is female and at least 18 years of age; AND • Prescriber is enrolled in the Prometheus Prescribing Program for Lotronex[®], AND • Patient has had chronic IBS symptoms for at least 6 months; AND • Patient has tried and failed at least three agents from the following ○ bulk producing agents (e.g., psyllium, fiber), ○ antispasmodic agents (e.g., dicyclomine, hyoscyamine), ○ antidiarrheal agents/opiates (e.g., loperamide, diphenoxylate/atropine, codeine)
Proton Pump Inhibitors		
pantoprazole	Aciphex [®] DR tab/ <i>sprinkle</i>	LENGTH OF AUTHORIZATIONS:



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	Prilosec® OTC	Dexilant® esomeprazole strontium lansoprazole (SA not required for soln if age < 12yrs) Nexium® omeprazole (RX & OTC) omeprazole/sodium bicarbonate Prevacid® RX, OTC& Solutab rabeprazole DR tab Prilosec® Rx & Susp Protonix® Zegerid® cap, OTC & Susp packet	12 weeks; unless patient meets an exception; then 1 year Routine PDL edit plus <u>Additional PDL edit criteria</u> The requested medication may be approved if both of the following are true: - If there has been a therapeutic failure of no less than a three-month trial of at least two different medication within the same class not requiring service authorization <u>Exceptions that allow for a 1 year SA for PPIs</u> (Exceptions apply to the duration of the SA only. PDL edit still prevails before a non-preferred may be approved) - Erosive Esophagitis - Active GI Bleed - Zollinger-Ellison Syndrome - Greater than 65 years of age - Under the care of a Gastroenterologist and has ruled out a nonsecretory condition
Ulcerative Colitis Oral and Rectal Preparations (5-ASA DERIVATIVES)			
Ulcerative Colitis – Oral			<u>LENGTH OF AUTHORIZATIONS:</u> 1 year
	Asacol® Apriso® balsalazide disodium Pentasa® sulfasalazine DR & IR	Asacol® HD Azulfidine® IR & DR Colazal® Delzicol™ Dipentum *Giazo™ Lialda® Uceris™	Routine PDL edit *Giazo is limited to an 8 week supply
Ulcerative Colitis – Rectal			
	Canasa® rectal supp mesalamine enema	Fiv-Asa® mesalamine kit Rowasa® enema/supp/kit SFRowasa®	
Genitourinary			
Alpha-Blockers and Androgen Hormone Inhibitors For Benign Prostatic Hypertrophy (BPH)			
Alpha-Blockers for BPH			<u>LENGTH OF AUTHORIZATIONS:</u> 1 year
	alfuzosin	Flomax®	



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	tamsulosin HCL	Rapaflo [®] Uroxatral [®]	Routine PDL edit plus
Androgen Hormone Inhibitors for BPH			*Step edit for <u>Avodart</u> [®] - the generic finasteride must be tried and failed before approval
*Avodart [®] finasteride	Jalyn [®] Proscar [®]		
Phosphodiesterase (PDE) 5 Inhibitor for BPH			
	**Cialis [®]		**Step edit for <u>Cialis</u> [®] - must try and fail both Alpha Blockers and Androgen Hormone Inhibitors for BPH and the prescriber must attest that the patient is not on the state list of sex offenders. The patient must have had a consult or been evaluated by an Urologist.
Phosphate Binders			
calcium acetate 667mg cap Fosrenol [®] Renagel [®]	calcium acetate 667mg tab Eliphos [®] Phoslo [®] Phoslyra [®] Renvela [®] powder/tablet sevelamer carbonate Velphoro [®] chewable tablet	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit	
Urinary Antispasmodics			
oxybutynin tab/syrup Oxytrol [®] transdermal Sanctura [®] XR Toviaz [™] VESIcare [®]	Detrol [®] & Detrol [®] LA Ditropan [®] & *Ditropan [®] XL Enablex [®] flavoxate [™] Gelnique [™] gel Myrbetriq [™] *oxybutynin ER Sanctura [®] trospium IR & ER tolterodine IR & ER	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit <u>*Oxybutynin ER, Ditropan XL[®]:</u> Allow PDL exception for children age 6-18 with a diagnosis of neurogenic bladder.	
Immunological Agents			
Atopic Dermatitis: Topical			
*Elidel [®]	*Protopic [®]	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit plus	



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		*Clinical Criteria for Atopic Dermatitis, Topical ➤ Elidel[®] and Protopic[®] • Patient must have a FDA approved diagnosis: ○ Atopic dermatitis (a type of eczema): ○ Elidel[®] : mild to moderate for ages > 2 years. ○ Protopic[®] 0.03%: moderate to severe for ages > 2 years. ○ Protopic[®] 0.1%: moderate to severe for ages > 18 years. • Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.)
Multiple Sclerosis		
Avonex[®] Avonex[®] Adm Pack Copaxone Kit[®] Extavia[®] Kit & Vial Rebif[®] SQ	*Ampyra[®] Aubagio[®] Betaseron[®] Copaxone[®] 40 mg syringe[®] Gilenya[®] Rebif[®] Rebi dose Pen[®] Tecfidera[™]	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit plus Gilenya[®] is to be used as monotherapy ONLY. *Clinical Criteria for AMPYRA[®] • The patient has a diagnosis of Multiple Sclerosis and a gait disorder. • Patient has no history of seizures • Patient's Creatinine Clearance [CrCL] ≥ 50 mL/min. • If after 8 week trial the prescriber states that the patient showed improvement or that the drug was effective (by improved Timed 25-foot Walk), the patient may receive authorization for Ampyra[®] for one year.
Self Administered Drugs for Rheumatoid Arthritis		
Enbrel[®] Humira[®]	Actemra[®] SQ Cimzia[®] Cimzia[®] Syringe Kit Kineret[®] Otezla[®] Orencia[®] Simponi[®] *Xeljanz[™]	<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit plus Clinical Criteria for *Xeljanz[™] • For the treatment of moderately to severely active rheumatoid arthritis in patients who have had an inadequate response or intolerance to methotrexate. • The patient had a therapeutic trial and treatment failure with ONE of the following preferred drugs: Enbrel[®], or Humira[®], AND • Trial and failure of methotrexate therapy.



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Ophthalmic		
Antibiotics		
bacitracin/polymyxin b sulfate ointment ciprofloxacin drops erythromycin gentamicin drops/oint Moxeza [®] drops neomycin/polymyxin/gramicidin ofloxacin drops polymyxin/trimethoprim sulfacetamide soln tobramycin Vigamox [®] drops	AzaSite [™] drop bacitracin Besivance [®] drops Bleph [®] - 10 Ciloxan [®] drops/oint Garamycin [®] drops/oint gatifloxacin 0.5% soln Ilotycin [®] levofloxacin drops Natacyn [®] neomycin/bacitracin/polymyxin ointment Neosporin [®] Ocuflox [®] drops Polytrim [®] sulfacetamide ointment Tobrex [®] drops/ointment Zymaxid [®] drops	<u>LENGTH OF AUTHORIZATIONS:</u> for the date of service only; no refills Routine PDL edit
Antibiotic/Steroid Combinations		
neomycin/polymyxin/dexamethasone oint/susp Tobradex [®] oint/susp	Blephamide [®] & Blephamide [®] S.O.P. Maxitrol [®] Oint. & Susp neomycin/bacitracin/poly/ HC neomycin/polymyxin/HC Pred-G [®] oint/susp sulfacetamide/prednisolone Tobradex [®] ST Tobramycin/dexamethasone susp Zylet [®]	<u>LENGTH OF AUTHORIZATION:</u> for the date of service only; no refills Routine PDL edit



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Antihistamines/Mast Cell Stabilizers			
Antihistamines			LENGTH OF AUTHORIZATIONS: 1 year Routine PDL edit *Ilevro™ is limited to 1 bottle plus 1 refill
Alaway OTC® ketotifen fumerate Pataday® drops Zaditor® OTC drops		azelastine drops Bepreve® Elestat® drops Emadine® drop epinastine 0.05% eye drops *Ilevro™ 0.3% drops Lastacast® drops Optivar® drops Patanol® drops	
Mast Cell Stabilizers			
cromolyn sodium		Alocril® drops Alomide® drops Crolom® drops	
Anti-inflammatory			
NSAIDS			LENGTH OF AUTHORIZATIONS: for the date of service only; no refills Routine PDL edit *Ilevro™ is limited to 1 bottle plus 1 refill
diclofenac sodium flurbiprofen sodium ketorolac 0.4% & 0.5% Nevanac®		Acular® 0.5% & LS® 0.4% Acuvail® bromfenac 0.09% Ilevro™ 0.3% drops Ocufen® Prolensa™	
Corticosteroids			
Durezol® fluorometholone prednisolone acetate		Alrex™ dexamethasone Flarex® FML® FML Forte® FML® S.O.P. Lotemax™ drops/gel/oint Maxidex® Omnipred® Pred Forte® Pred Mild®	



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		prednisolone sod phosphate Vexol®	
Glaucoma Agents			
Alpha 2 Adrenergic Agents			LENGTH OF AUTHORIZATIONS: 1 year
Alphagan P® 0.1 & 0.15% brimonidine 0.2% Iopidine® 0.5% & 1%		apraclonidine 0.5% drops brimonidine tartrate 0.15%	Routine PDL edit
Beta Blockers			
Betimol® 0.25% & 0.5% Betoptic-S® 0.25% carteolol 1% levobunolol 0.25% & 0.5% metipranolol 0.3% timolol maleate		<i>Betagan® 0.25% & 0.5%</i> <i>betaxolol 0.5%</i> <i>Combigan®</i> <i>Istalol® 0.5%</i> <i>optipranolol 0.3%</i> <i>Timoptic® drops 0.25% & 0.5%</i> <i>Timoptic® XE 0.25% & 0.5% sol-gel</i>	
Carbonic Anhydrase Inhibitors			
Azopt® 1% dorzolamide dorzolamide/timolol Simbrinza™		<i>Cosopt® 0.5%-2%</i> <i>Cosopt® PF</i> <i>Trusopt® 2%</i>	
Prostaglandin Analogs			
latanoprost Travatan Z®		<i>Lumigan® 0.03% & 0.01%</i> <i>Rescula®</i> <i>travoprost 0.004%</i> <i>Xalatan® 0.005%</i> <i>Zioptan™</i>	



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Respiratory					
Antihistamines: First and Second Generation					
First Generation Antihistamines			LENGTH OF AUTHORIZATIONS: 1 year		
Generic only class		All Brands require a SA		Routine PDL edit	
Second Generation Antihistamines and Combinations					
cetirizine liquid 1mg/1mL (RX/ OTC) cetirizine tabs OTC loratadine tab/syrup OTC		Allegra® Allegra-D® cetirizine chew tab (OTC) cetirizine liquid 5mg/5mL (OTC) cetirizine D tab (OTC) Clarinex® Clarinex-D® Claritin® Claritin® D desloratadine ODT fexofenadine fexofenadine/PSE & 60/120 ER levocetirizine loratadine ODT loratadine D 12 & 24 hr Xyzal® Zyrtec® tab/chew/syrup (OTC/RX) Zyrtec-D® (OTC/ RX)			
Beta-Adrenergic Agents					
Long Acting Beta Adrenergic agents (LABA) Metered Dose Inhalers or Nebulizers			LENGTH OF AUTHORIZATIONS: 1 year		
*Foradil® *Serevent Diskus®		*Arcapta Neohaler® *Brovana® *Perforomist®		Routine PDL edit plus	
*Clinical Criteria for LABAs					
Length of Authorization 3 months for Clinical Criteria					
Each product listed below will require a SA for ages less than the FDA/PI indicated age.					
Brand Name			Age where SA is required		
Advair® Diskus2 50/50, & 500/50			Children < 12 years		
Advair® Diskus 100/50			Children < 4 years		



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			Advair [®] HFA	Children < 12 years
			Anoro [™] Ellipta	Children & Adolescents < 18 years
			Arcapta [®] Neohaler	Children & Adolescents < 18 years
			Brovana [®]	Children & Adolescents < 18 years
			Dulera [®]	Children < 12 years
			Foradil [®] Aerolizer	Children < 5 years
			Perforomist [®]	Children & Adolescents < 18 years
			Serevent [®] Diskus	Children < 4 years
			Symbicort [®]	Children < 12 years
Short Acting Metered Dose Inhalers or Devices				
Proventil [®] HFA	Maxair Autohaler Proair [®] HFA Ventolin [®] HFA Xopenex [®] HFA			
Short Acting Nebulizers				
albuterol sulfate all premix metaproterenol Xopenex [®]	levalbuterol soln			
COPD: Bronchodilators and Phosphodiesterase 4 (PDE4) Inhibitors				
Atrovent HFA [®] Combivent [®] MDI Combivent [®] Respimat ipratropium bromide soln ipratropium/albuterol nebs Spiriva [®]	Anoro [™] Ellipta Daliresp [®] Duoneb [®] Tudorza [™]		<u>LENGTH OF AUTHORIZATION:</u> 1 year Routine PDL edit plus <u>Clinical Criteria for Daliresp[®]</u> - If the patient has a diagnosis of severe COPD associated with chronic bronchitis and a history of exacerbations <u>and</u> - Trial/failure on at least one first-line or second-line agent (inhaled anticholinergics, long acting beta agonists or inhaled corticosteroids) <u>and</u> - Adjunctive therapy (Daliresp[®] must be used in conjunction with first-line or second-line agent)	
Corticosteroids: Inhaled and Nasal Steroids				
Inhaled Corticosteroids: Combination Products (Glucocorticoid and Long Acting Beta Adrenergic)			<u>LENGTH OF AUTHORIZATIONS:</u> 1 year	
*Advair [®] Diskus & HFA *Dulera [®] *Symbicort [®]	Breo [®] Ellipta [™]		Routine PDL edit	



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Inhaled Corticosteroids: Metered Dose Inhalers			
Asmanex [®] Flovent [®] Diskus & HFA Pulmicort Flexhaler [®] QVAR [®]		Alvesco [®] Aerospan [™]	
Inhaled Corticosteroids: Nebulizer Solution			
Pulmicort [®] Respules		Budesonide	
Nasal Steroids			
Nasonex [®]		Beconase AQ [®] Dymista [™] Flonase [®] flunisolide fluticasone Nasacort [®] AQ Nasarel [®] Omnaris [®] Qnasl [™] Rhinocort Aqua [®] triamcinolone acetonide Tri-Nasal [®] Veramyst [®] Zetonna [™]	
Cough and Cold products			
Drug Name and GNN	All other Legend cough	LENGTH OF AUTHORIZATION: Date of Service only	
Ala-Hist DM brompheniramine/ phenylephrine/ dextromethorphan benzonatate cap codeine/ promethazine Carbatuss-12 [®] Carbetapen cit, carbetap tan, PE HCL PE Tan guaifenesin/codeine phosphate	and cold products are non-preferred Tessalon [®] perle	Routine PDL edit <u>Clinical Edit for Cough and Cold Agents</u> – All children under 6 will not be eligible for cough and cold products.	



Virginia Medicaid Preferred Drug List With Service Authorization Criteria
Effective July 1, 2014



Preferred Agents	Non-Preferred Agents	SA Criteria
hydrocodone/ homatropine iophen-C NR <i>guaifenesin/codeine phosphate</i> Lohist-DM syrup <i>brompheniramine/ dextromethorphan/ phenylephrine</i> phenylephrine HCl/promethazine HCl poly hist DHC <i>pyrilamine/ phenylephrine/ dihydrocodeine</i> poly-tussin DHC <i>brompheniramine/ phenylephrine/ dihydrocodeine</i> promethazine DM syrup Tusnel® Pediatric Drops <i>dextromethorphan/guaifenesin/pseudoeph edrine</i>		
Intranasal Antihistamines		
Astepro® 0.15% Patanase®	<i>azelastine 0.1%</i>	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit
Leukotriene Receptor Antagonists		
Accolate® montelukast tabs/chew tabs/granules	<i>Singulair® tabs/chew tabs/ granules zafirlukast Zyflo™ Zyflo CR™</i>	<u>LENGTH OF AUTHORIZATIONS:</u> 1 year Routine PDL edit